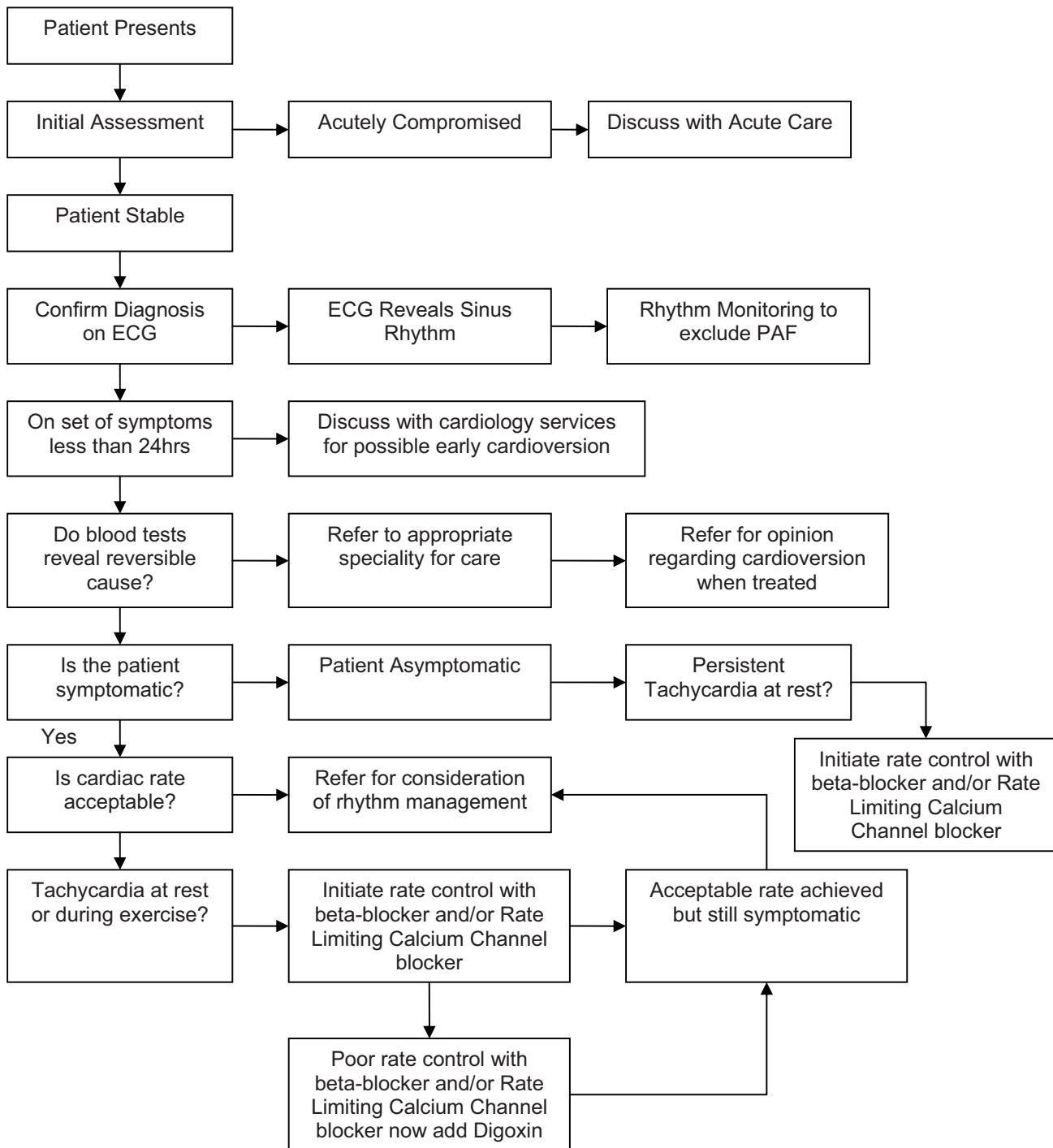


Primary Care Pathways For Atrial Fibrillation - Information for Medical Professionals



Atrial Fibrillation (AF) is the commonest sustained cardiac arrhythmia with a prevalence of around 1 in 20 of the over 65s in the UK and is more prevalent towards the older end of the age spectrum. The number of patients with AF roughly doubles with each advancing decade of age peaking at around 8-9% of 80-90 year olds.

The Initial Assessment: Patients who present with Atrial Fibrillation are generally in a stable situation. However on initial assessment if the patient is cardiovascularly compromised then discussion with the local acute service is recommended with the possibility of admission.

It is also important to consider the acute setting in which Atrial Fibrillation can present. Atrial Fibrillation can be the presenting feature of a Pulmonary Embolism, Acute Myocardial Infarction and Acute Pneumonic Illness. If the history is suggestive of this or alternatively there has been a very acute onset (see below) then discussion with the local acute service is recommended.

Paroxysmal Atrial Fibrillation: If a patient is clinically in Atrial Fibrillation when they originally present and are found to be in sinus rhythm at the time of their ECG then a consideration must be made regarding paroxysmal Atrial Fibrillation. Arranging a period of ambulatory monitoring may assist in this setting.

The thromboembolic risk of paroxysmal Atrial Fibrillation should be calculated in the same way as for persistent and permanent Atrial Fibrillation.

Acute Cardioversion: Patients in persistent Atrial Fibrillation who give a reliable history of the onset of symptoms in the preceding 24 hours have a window of opportunity for cardioversion prior to clot formation in the

atria. In this setting it would be advisable to discuss with the on call cardiology team.

Symptomatic Atrial Fibrillation: If a patient is symptomatic in Atrial Fibrillation then consideration must be made of treatment options. If they are symptomatic at acceptable heart rates then a return to sinus rhythm strategy must be considered. This may be achieved with simple cardioversion with or without anti arrhythmic therapy or may require review by an Electrophysiologist for consideration of ablation.

If the patient is found to be symptomatic and tachycardic then a rate limiting strategy can be considered. This should initially be commenced with either a beta-blocker or the Rate Limiting Calcium Channel blocker, Diltiazem. If this solo agent is not successful at controlling the rate then the other option should be co-prescribed unless contraindicated. If this dual prescription still does not control the symptoms or reduce the rate then Digoxin may be commenced. It may be appropriate at this stage to refer for consideration of rhythm management.

If the patient is asymptomatic but persistently tachycardic then there is a risk of developing a tachycardia-induced cardiomyopathy and rate control should be commenced to prevent this possibility as described above.

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